

**DEPARTMENT OF STATE HEALTH SERVICES****Radiation Safety Licensing Branch****Mammography Certification****Application for New Facility Performing Stereotactic Biopsy, Needle Localizations or Image Guided Radiotherapy**

Complete this application and submit to either address below. (Use supplemental sheets as necessary) Retain a copy of the application for your files.

**U.S. Postal service address:**

Department of State Health Services  
Radiation Safety Licensing Branch  
Mammography Certification Program  
P.O. Box 149347, Mail Code (MC) 2835  
Austin, Texas 78714-9347

**Overnight/express service address**

Department of State Health Services  
Radiation Safety Licensing Branch  
Mammography Certification Program  
1100 West 49th Street  
Austin, Texas 78756

Mammography Certification Program (512) 834-6688 - Fax (512) 834-6716

**Section 1: General Information**

Legal Name of Facility: \_\_\_\_\_  
(Name should match that on Business Information Form RC 226-1)

Doing Business As (if applicable): \_\_\_\_\_  
(Name should match that on Business Information Form RC 226-1)

County \_\_\_\_\_

Mailing Address: (Street/City/State/Zip)      Machine Use Location Address: (Street/City/State/Zip)  
(If multiple use locations, use additional sheets)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Facility Phone Number: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Radiation Safety Officer (RSO): \_\_\_\_\_  
Attach qualifications as required in 25 TAC § 289.226(t)(1).

Telephone No.: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Contact Person & Title: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Total number of machines:

Stereotactic Biopsy Units: \_\_\_\_\_ Needle Localization Only Units: \_\_\_\_\_

Image Guided Radiotherapy Units: \_\_\_\_\_ Stereotactic Biopsy Attachments: \_\_\_\_\_

## Section 2: Equipment Information

Complete this section for each mammographic biopsy or needle localization unit.

**Include a copy of the medical physicist's survey report for each machine and corrective actions for all failures and/or deficiencies noted.** (The survey report must be dated within the past 6 months).

Indicate the service for which this unit is used: ☐ Needle Localization ☐ Breast Biopsy

1. Control Panel Manufacturer: \_\_\_\_\_ Control Panel Model Name & Number: \_\_\_\_\_ Control Panel Serial Number: \_\_\_\_\_

Stereotactic Biopsy Attachment  
Manufacturer \_\_\_\_\_

Model Number \_\_\_\_\_

Serial Number \_\_\_\_\_

2. Type of Imaging System: ☐ Screen/Film ☐ Digital

3. Location: ☐ Onsite ☐ Mobile

## Section 3: Accreditation Information

*Accreditation is voluntary and only available through the American College of Radiology*

Please check if unit is accredited ☐ American College of Radiology (ACR)

## Section 4: Mobile Service Operation

*Authorization from the Department is required prior to initiating mobile service operations.*

For mobile mammography service operations complete this section.

[25 TAC§289.230(l)(8)]

Main location where machine and records will be maintained for inspection. This must be a street address.

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

**Attach** a sketch or description of the normal configuration of the mammography unit's use including the operator's position and any ancillary personnel's location during exposures. If a mobile van is used with a fixed unit inside, furnish the floor plan indicating protective shielding and the operator's location.

**Submit** a current copy of the mobile service operations operating and safety procedures regarding radiological practices for protection of patients, operators, employees, and the general public.

## Section 5: Signatures

I certify that all information submitted with this application is true and current to the best of my knowledge.

\_\_\_\_\_  
Typed or printed name of person completing  
the application

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Typed or printed name and title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*This shall be the signature of the Administrator, President, Chief Executive Officer, Owner or Partner of the facility.*

As a licensed physician, I affirm that I am associated with this applicant and provide supervision to non-practitioners administering radiation to human beings.

\_\_\_\_\_  
Typed or printed name of licensed physician  
(Include current copy of Texas Board of Medical Examiner's License)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

I assume the responsibilities of **RSO** as described in 25 TAC §289.226(t)(2) for the facilities listed in this application. I certify that all information submitted with this application is true and current to the best of my knowledge.

\_\_\_\_\_  
Typed or printed name of RSO

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**NOTE: Please include completed Business Information Form BRC 226-1**

PRIVACY NOTIFICATION: If you are applying as an individual, with few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)